how we can correct them with a good bill, like the Patients' Bill of Rights, is by giving some real life examples.

Mr. Speaker, I yield to the gentleman from Ohio (Mr. STRICKLAND), who would like to give us some examples of the problems that we face. After that, we are going to have the gentleman from Iowa (Mr. GANSKE) go on and explain why we need real form.

Mr. STRICKLAND. Mr. Speaker, I thank my colleague for yielding.

Mr. Speaker, it is true that patients in this country are being deprived of essential and necessary health care, oftentimes resulting in their death, because managed care companies are placing profits above the needs of patients. I would like to share with my colleagues two stories, two real-life stories from my district. One involved a long-time friend of mine, and I will use his name, because before his death he gave me permission to talk about his situation on the floor of this House. His name was Jim Bartee.

He was a person younger than I am, someone that I had known for many, many years. Jim grew up in Portsmouth, Ohio. He went to Florida and became a publisher of a small newspaper. He developed leukemia, and he came back home for treatments. While he was in the hospital, getting chemotherapy, he called his managed care case manager and he was talking about his situation.

She said to him, ''How are you doing, Jim?''

He said to her, ''Well, I am feeling a little sick now because of the chemotherapy.''

She said, ''Well, if you need a couple of more days in the hospital, I can approve that for you.''

He said, ''Well, what I really needed to talk with you about was a conversation I had with my doctor this morning.'' He said, ''My doctor came in and told me that I have perhaps as little as 3 weeks to live, and that my only hope for survival may be a bone marrow transplant.''

She responded, this managed care case manager responded, by saying, ''Oh, we could never get it approved that quickly.''

He said to her, ''How much would it cost?''

She said, ''Probably somewhere in the vicinity of $120,000.'' She said, ''Jim, we just could not get it approved that quickly.''

So, my friend, who had been a newspaper publisher, called his newspaper in Florida and told them what his managed care case manager had said to him. They said to him, ''Jim, whatever you need, medically, do not worry about the cost. We will make sure it is paid for.''

As it turned out, a bone marrow transplant was not indicated, according to his doctor, eventually, and so Jim passed away. I spoke at his funeral. He was one of the bravest, one of the kindest people I have ever known in my life.

I would say to my colleague, the gentleman from New Jersey, my reason for sharing this story is this: No one facing a death threatening medical set of circumstances should be told by an insurance bureaucrat, we cannot approve this treatment in time. That is a decision that ought to be made by a physician and the patient.

I share this story because before Jim Bartee died, he told me that he would like for me to share with others what his experience had been.

Then a second circumstance that occurred in my district was a young man who grew up in one of my counties and went to California to go to college, and he affiliated with a managed care organization out there. He came back home for a visit and went hiking and fell some 80-some feet and damaged his brain, and he has been in a coma ever since.

After the fall, he was immediately taken to surgery in Cincinnati, Ohio, and a few days after surgery the managed care company informed his parents that they would no longer provide medical coverage unless he was in one of their facilities. So the patients allowed this young man to be air transported to California. The mother took a leave of absence. She is a schoolteacher. She took a leave of absence to go to California to be near her son.

The week before Christmas, they contacted my office and they told me the care that he had received there: Lack of physical therapy, his teeth rarely being brushed, his body not being turned every two hours as it needed to be turned in order to keep him from getting bed sores. When they contacted me, they told me that the managed care company told them that his coverage would expire on January 1, and that thereafter they would be responsible for his medical costs.

At that point, they asked if he would be returned to Ohio. They said it is against our company policy. It was not until my office got involved and we literally threatened to make this the Christmas story of 1997 that on Christmas Eve day they finally relinquished and told his parents that they would fly him back to Ohio.

He is now in Ohio in a nursing home and he remains in a coma.

I talked to the father recently, and he said while his son was in California, a large swollen area developed on his skull and that they tried to get the managed care company to have him seen by a specialist, and it was put off and put off and put off until his coverage expired. Once he got back to Ohio and the physician saw him in Ohio, they said, this needs immediate attention.

They discovered that he had an existing serious infection that had been neglected for a long, long time. The father believes that that managed care company refused to evaluate his condition simply because they did not want to bear the cost of the necessary treatment.

These are the things that are happening to my constituents and to real Americans, and every Member of this House, Republican and Democrat alike, should stand together to say, we are no longer going to tolerate American citizens being abused in these kinds of ways. That is why I am really proud of the gentleman from Iowa (Mr. GANSKE).

Many people may not know that the gentleman from Iowa (Mr. GANSKE) is himself a physician. He has joined with some of the rest of us to fight this fight to make sure that patients come first, and that profits, while essential and necessary for any corporation or any business, should not be put first and patient needs put second or third or fourth.

So I am pleased that you have given me the time to talk about my constituents and the problems they have had. I encourage you, my colleague, the gentleman from New Jersey, to continue your fight for all of us.

Mr. PALLONE. Mr. Speaker, we have very little time left, but I want to thank the gentleman from Ohio (Mr. STRICKLAND) for giving us those two examples. All I can say again, and I am sure that the gentleman from Iowa (Mr. GANSKE) will say the same, is that this is happening on a regular basis. These are not isolated instances. We are getting these kinds of problems on a daily basis in our districts, and that is why it is so important that we pass the Patients' Bill of Rights.

☐ 1845

MAJOR DIFFERENCES EXIST IN HEALTH CARE LEGISLATION

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentleman from Iowa (Mr. GANSKE) is recognized for 45 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, I am glad to join my colleagues this evening to discuss managed care legislation. Yesterday the House returned from the August district work period when Members were scattered across the Nation for the past month, and yesterday Judge Starr delivered his report to Congress. I would hope that we will be able to get some work done in this Congress besides just dealing with the Starr report before we leave for the year.

When Members were back in their districts, they had the opportunity to speak with constituents at countless county and state fairs, town hall meetings and other gatherings, both formal and informal. It was an opportunity for us to communicate what we have done and for the voters to tell us what they would like Congress to do.

I suspect that my colleagues had experiences similar to mine. It was almost impossible to pick up a newspaper or hold a town meeting without hearing another story about how a managed care plan had denied someone lifesaving treatment. No public opinion

poll can convey the depth of emotion about this issue as well as movie audiences around the country, who spontaneously clapped and cheered Helen Hunt's obscenity-laced description of her HMO.

Mr. Speaker, I rise today to offer some thoughts on what sorts of meaningful managed care reforms Congress must pass before adjourning for the year. At the end of July, the House approved a Republican bill which was advertised as addressing consumer complaints about HMOs. But, Mr. Speaker, I think an examination of the fine print is in order, particularly when we compare it to the Patients' Bill of Rights, a bipartisan proposal that I and the gentleman from New Jersey (Mr. PALLONE) support, which has been endorsed by close to 200 national groups of patients and providers, including now the Patient Access to Responsible Care Act Coalition, the PARCA coalition, as well.

A year ago, Congress and the President were able to reach agreement on a plan to save Medicare from bankruptcy. Included in that package were several provisions to protect seniors enrolled in Medicare HMOs. One of the most important parts was language to ensure that health plans pay for visits to emergency rooms.

We had heard frequent complaints that health plans were denying payment if the individual was found after the evaluation not to have a serious condition. The best example is a man who experiences crushing chest pain. The American Heart Association says that is a sign of a possible heart attack and urges immediate medical attention. Fortunately, there are other causes of crushing chest pain besides a heart attack. But seniors, whose EKG tests were normal, were then being stuck with a bill for the emergency care, since in retrospect the HMO said, ''See, the EKG was normal. You did not need the treatment after all.''

Well, the Medicare law that we passed last year took care of that problem by ensuring that plans paid for emergency room services if a ''prudent layperson'' would have thought a visit to the ER was needed. This prevented the sort of 20–20 hindsight coverage denials that consumers had complained about from their HMOs.

The Patients' Bill of Rights that I support would have extended the same protections to consumers in all HMO's that we passed for senior citizens. Instead, the Republican bill passed by the House contains a watered-down version of the prudent layperson rule.

Last month, the New York Times published an excellent article by their noted health reporter, Robert Pear. In it Mr. Pear outlined just how different the protections in the Republican bill are from those we passed last year for Medicare and Medicaid. A key difference is exactly how much patients will have to pay for emergency care.

The Patients' Bill of Rights, which I and my colleague, the gentleman from New Jersey supported, provides that patients could not be charged more money if they seek care in a non-network emergency room. By contrast, the Republican bill allows the health plan to impose higher costs on those who are so careless as to allow emergencies to befall them in places not close to a network hospital.

Mr. Speaker, consider what this means: HMOs require enrollees to use certain hospitals because the plan has a financial arrangement with those hospitals. But when a young child splits open his head by falling down a flight of stairs, I fail to see that any good is served by requiring that little child to delay timely care until his parents can get him to one of the HMO's emergency rooms.

Consider the case of James Adams, age six months. At 3:30 in the morning his mother, Lamona, found James hot, panting and moaning. His temperature was 104 degrees. Lamona phoned her HMO and was told to take James to the Scottish Rite Medical Center. ''That is the only hospital I can send you to,'' said the HMO nurse.

''How do I get there,'' Lamona asked? ''I don't know,'' the nurse said. ''I am not good at directions.'' Well, about 20 miles into their ride they passed the Emory Hospital, a renowned pediatric center. They passed two more of Atlanta's leading hospitals, Georgia Baptist and Grady Memorial, but they did not have permission to stop there.

So they drove on. They had 22 more miles to travel to get to the Scottish Rite Hospital. And while searching for Scottish Rite, James's heart stopped.

When James and Lamona finally got to Scottish Rite, it looked like the little boy would die. But he was a tough little guy, and, despite his cardiac arrest due to the delay in treatment by his HMO, he survived. However, the doctors had to amputate both of his hands and both of his feet because of resulting gangrene. All of this is documented in this book, ''Health Against Wealth.'' As the details of baby James' HMO's methods emerged, the case suggests that the margins of safety in HMOs can be razor thin. In James' case, they were almost fatal, leaving him without hands and without feet for the rest of his life.

Think of the dilemma that places on a mother struggling to make ends meet. In Lamona's situation, under the Republican bill if she rushes her child to the nearest emergency room, she could be at risk for charges that average 50 percent more than what the plan would pay for for in-network care; or she could hope that her child's condition will not worsen as they drive past other hospitals, an additional 20 miles, to get to the nearest ER affiliated with their plan. And woe to any family's fragile financial condition if this emergency occurs while they are visiting relatives in another state.

Mr. Speaker, the other bill, the Patients' Bill of Rights, would ensure that consumers would not have to make that potentially disastrous choice.

A second key difference between the Republican bill and the protections already enacted for Medicare is that the Republican bill does not require any payment for services other than an initial screening. After that, payment must be made only for additional emergency services if ''a prudent emergency medical professional'' would deem them necessary. Moreover, the GOP bill added a new burden on emergency room doctors, requiring them to certify in writing that such services are needed.

Talk about bureaucracy. Robert Pear's New York Times article quoted John Scott of the American College of Emergency Physicians. Mr. Scott's comments bear repeating, because I think they illuminate the weakness in the Republican bill. ''We have more than a century of common law and court decisions interpreting the standard of a prudent layperson, or reasonable man, as it used to be called. But this new standard of a prudent emergency medical professional was invented out of thin air. It creates new opportunities for HMOs to second-guess the treating physician and to deny payment for emergency services.''

Mr. Pear's article also takes a hard look at the difficult issue of medical records privacy and concludes that, ''On this issue too, the details have provoked a furor'' in the Republican bill. He noted that privacy advocates were amazed to learn that the Republican task force bill authorizes the disclosure of information without an individual's consent for a broad range of purposes, including risk management, quality assessment, disease management, underwriting and more.

The Republican bill considers disclosure for ''health care operations'' as permissible. This is a term so broad that many critics say it would allow the transfer of patient information to companies marketing new drugs.

Commenting on these flaws in the Republican bill, noted privacy act expert Robert Gellman said the Republican bill ''gives the appearance of providing privacy rights, but it may actually take away rights that people have today under state law or common practice.''

Mr. Speaker, I will include the entire text of the Robert Pear article for the RECORD at this point.

[From the New York Times, Aug. 4, 1998]

COMMON GROUND ON PATIENT RIGHTS HIDES A CHASM

(By Robert Pear)

WASHINGTON, AUG. 3.—It has been clear that there are major differences to be worked out between the Democratic and Republican bills on patient rights.

But a look at the details of the House Republican plan shows that there are also major differences in important areas on which the two sides had seemed to agree.

The disagreements are illustrated in two areas: emergency medical services and the privacy of patients' medical records.

At first, it appeared that members of Congress agreed that health maintenance organizations should be required to pay for emergency medical care. And they seemed to agree on a standard, promising ready access to emergency care whenever ''a prudent lay person'' would consider it necessary. After all, that was the standard set by Congress last year for Medicare, the Federal health program for 38 million people who are elderly or disabled.

But the consensus dissolved when emergency physicians read the fine print of the House Republicans' bill, the Patient Protection Act, which was introduced on July 16 by Speaker Newt Gingrich and passed eight days later by a vote of 216 to 210.

Since 1986, the Government has required hospitals to provide emergency care for anyone who needs and requests it. But the question of who should pay for such care has provoked many disputes among insurers, hospitals and patients.

The Democratic bill would require H.M.O.'s and insurance companies to cover emergency services for subscribers, ''without the need for any prior authorization,'' regardless of whether the doctor or hospital was affiliated with the patient's health plan. Emergency services, as defined in the bill, include a medical screening examination to evaluate the patient and any further treatment that may be required to stabilize the patient's condition.

The H.M.O. would have to cover these services if ''a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention'' to cause serious harm.

By contrast, the House and Senate Republicans bills would establish a two-step test. An H.M.O. or an insurance company would have to cover the initial screening examination if a prudent lay person would consider it necessary. But the health plan would have to pay for additional emergency services only if ''a prudent emergency medical professional'' would judge them necessary. And under the House Republican bill, the need for such services must be certified in writing by ''an appropriate physician.''

Mr. Gingrich said the Republicans' bill would guarantee coverage for ''anybody who has a practical layman's feeling that they need emergency care.''

But Representative Benjamin L. Cardin, Democrat of Maryland, said the bill ''is not going to do what they are advertising.''

One reason, Mr. Cardin said, is that the bill was rushed through the House. ''There have been no hearings on the Republican bill,'' he said. ''It did not go through any of the committees of jurisdiction for the purpose of markup or to try to get the drafting done correctly.''

Under the Democratic bill, H.M.O. patients who receive emergency care outside their health plan—whether in a different city or close to home—may be charged no more than they would have to pay for using a hospital affiliated with the H.M.O. There is no such guarantee in the Republican bills. And the cost to patients could be substantial.

The Congressional Budget Office estimates that the Democratic bill would require H.M.O.'s to pay for emergency room visits in half the cases where they now deny payment. And it says that the charge for emergency care outside the H.M.O. is typically 50 percent higher than at hospitals in the H.M.O. network.

John H. Scott, director of the Washington office of the American College of Emergency Physicians, said the protections for patients were much weaker under the Republican bills than under the Democratic bill or the 1997 Medicare law.

''We have more than a century of common law and court decisions interpreting the standard of a prudent lay person, or reasonable man, as it used to be called,'' Mr. Scott said. ''But this new standard of a prudent emergency medical professional was invented out of thin air. It creates new opportunities for H.M.O.'s to second-guess the treating physician and to deny payment for emergency services. It would introduce a whole new level of dispute.''

Dr. Charlotte S. Yeh, chief of emergency medicine at the New England Medical Center in Boston, said, ''The Republicans performed some unnecessary surgery on the 'prudent lay person' standard, to the point that it's hardly recognizable as the consumer protection we envisioned.''

The Senate adjourned on Friday for its summer vacation without debating the legislation, but leaders of both parties said they hoped to take it up in September. Senate Republicans intend to take their bill directly to the floor, bypassing committees, which normally scrutinize the details of legislation.

There was, and still is, plenty of common ground if Republicans and Democrats want to compromise. Both parties' bills would, for example, require H.M.O.'s to establish safeguards to protect the confidentiality of medical records.

But on this issue too, the details have provoked a furor. When privacy advocates read the fine print of the House Republican bill, they were surprised to find a provision that explicitly authorizes the disclosure of information from a person's medical records for the purpose of ''health care operations.'' In the bill, that phrase is broadly defined to include risk assessment, quality assessment, disease management, underwriting, auditing and ''coordinating health care.''

Moreover, the House Republican bill would override state laws that limit the use or disclosure of medical records for those purposes.

The House Republican bill says patients may inspect and copy their records. But it stipulates that the patients must ordinarily go to the original source—a laboratory, X-ray clinic or pharmacy, for example—rather than to their health plan for such information.

Representative Bill Thomas, the California Republican who is chairman of the Ways and Means Subcommittee on Health, said the bill ''prohibits health care providers and health plans from selling individually identifiable patient medical records.''

Still, privacy advocates say the bill would allow many uses of personal health care data without the patients' consent.

Robert M. Gellman, an expert on privacy and information policy said: ''The House-passed bill gives the appearance of providing privacy rights. But it may actually take away rights that people have today under state law or common practice.''

Mr. Speaker, these are but two examples of flaws that may not be apparent on a quick read of the Republican bill, but which become apparent on closer examination. I wish I could say that those are the only two provisions in the House-passed Republican managed care reform bill, which, to borrow from an old TV ad, may taste great, but it is certainly less filling.

I think every Member would agree that the best health care bill is one that allows people to get the services they need, when they need them. Remedies such as internal and external appeals and access to the courts are needed backdrops, but our first goal should be to require that HMOs provide needed care. On that count, there is no comparison between the two bills.

Here is a partial list of protections contained in the Patients' Bill of Rights which are not included in the Republican bill. First and foremost, the Republican bill could actually make the situation worse by creating what are called association health plans, which would be beyond the reach of state regulation.

For years, states have shown themselves able to craft workable consumer protections for health insurance, but thanks to a 25-year-old Federal law known as ERISA, millions of Americans are in health plans that are beyond the reach of state consumer protections.

Instead of giving consumers more control over health care, the Republican bill actually places more people into ERISA regulated health plans. Does this solve our health care problems? Certainly not. Does it add to them by denying people the protections of state law? Definitely.

Instead of improving access to insurance, these proposals would have the exact opposite effect. By exempting multiple employer welfare arrangements, otherwise known as MEWAS, from a range of state insurance regulations, the Republican bill makes it more difficult for states to fund high risk pools and other programs that actually help keep health insurance more affordable.

The National Association of Insurance Commissioners and the National Conference of State Legislatures are concerned that these GOP provisions could ''undermine recent efforts undertaken by states to ensure that their small business communities have access to affordable health insurance.''

Take a look at this little boy, born with a cleft lip. In many states, HMOs are required to pay for coverage to give this little boy a normal face. But, Mr. Speaker, I would guess that many of my Republican colleagues would be very surprised to learn that because a cleft lip is considered a condition, rather than a disease, plans serving these HealthMarts in the Republican bill would not be required to cover needed treatments for this deformity.

This is not just my interpretation of the Republican bill. The Committee on Commerce staffer who helped draft this provision confirmed to me that HealthMarts would not be bound by state laws to require coverage of cleft lips and pallets and similar birth defects. If the Republican bill becomes law, I think it will be very difficult for Members to explain to parents of a child like this why Congress exempted HealthMarts from that state law protection.

Second, the Republican bill does not help doctors and nurses to serve as advocates for their patients. Both bills ban what are known as gag rules for some health plans that some health plans have used to limit discussions between patients and their health care

providers. But the Patients' Bill of Rights recognizes that doctors and nurses need to be advocates for their patients as well. It prevents health plans from taking action against those doctors and nurses for speaking up for their patients at internal and external reviews or for alerting public health authorities to safety concerns.

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These protections are not present in the Republican bill, and they should be.

A third key difference between the Republican bill and the bipartisan Patients' Bill of Rights relates to the way in which they deal with drug formularies. For reasons which may have more to do with financial discounts than quality medical care, many health plans have limited their coverage of prescription drugs to those on a formulary. For many conditions and diseases, patients can be given different formulations of a drug, whether brand names or generic, without harm. But that is not always the case. A patient may need a particular formulation of a drug. That is especially true for drugs for which there is a very narrow window between that which works and that which harms, and switching patients from brand name to generic drugs or vice versa can have serious health consequences.

The bill I support, the Patients' Bill of Rights, recognizes that by ensuring that physicians and pharmacists have input into the creation of that plan's, that HMO's formulary. Moreover, the bill ensures that there is a way for patients to get a drug that is not on the formulary if their physician determines that it is medically indicated.

By contrast, the Republican bill merely provides enrollees with information of the extent to which a drug formulary is used, and a description of how the formulary is developed. More specific information as to whether a particular drug is on the formulary is available only to those who ask.

A fourth key difference is that the Patients' Bill of Rights guarantees access to clinical trials, something that the Republican bill does not do. For patients with some diseases, the only hope for a cure lies in cutting edge clinical trials. The Patients' Bill of Rights would allow individuals with serious or life-threatening illnesses for which no standard treatment is effective to participate in clinical trials if participation offers a meaningful potential for significant benefit. This does not require the health plan to pay all of the costs of those clinical trials. In fact, all that the Patients' Bill of Rights requires is that a plan cover the routine costs they would otherwise be required to pay. They are not forced to assume any of the added costs of participation in a clinical trial.

The Republican managed care bill, by contrast, contains no similar protections. That can be a major difference for somebody with a life-threatening illness who would rather use his strength to battle his cancer, not to battle the insurance company for coverage of the clinical trial that might save his life.

A fifth important distinction between the competing proposals is that the Republican proposal does not provide for ongoing access to specialists for chronic conditions. Many chronic conditions, such as multiple sclerosis or arthritis, require routine care from specially trained physicians like neurologists or rheumatologists. It is one thing to ask an enrollee to get a referral for an isolated visit to a specialist, but those with chronic conditions need a standing referral to those specialists, or to be able to designate the specialist as their primary care provider. This protection is not in the Republican bill.

A sixth distinction between the 2 is that the Patients' Bill of Rights does more to ensure that individuals are able to see the doctor of their own choice. Both bills have a point-of-service provision that allows individuals to see health care providers not in their plan's closed panel. But the Republican bill contains a loophole that renders that protection a hollow one for millions of Americans.

Under the Republican bill, a health plan would not have to offer employees a point-of-service option if they could demonstrate that the separate coverage would be more than 1 percent higher than the premium for a closed panel, and this needs only to be a theoretical increase. The bill allows HMOs to provide only actuarial speculation that the costs would increase, and then they are relieved of having to offer employees the option. Perhaps even more amazing is the fact that that exemption is triggered even if employees selecting a point of service option would pay all of the costs of the improved coverage themselves.

Under the Republican bill, employees who are willing to pay the entire added cost for the ability to obtain out-of-network care can be denied access to this benefit if the employer is able to speculate that the costs might be higher. That is the ultimate in paternalism. The bipartisan bill I support, the Patients' Bill of Rights, lets the employees decide for themselves if they want to purchase that enhanced coverage.

A seventh key difference between the 2 bills is that the Patients' Bill of Rights ensures that health plans not place inappropriate financial incentives on providers to withhold care. Medicare regulations very explicitly limit the type of financial arrangements that HMOs can have with providers and protect seniors from providers who may get a financial windfall by delivering less care. That was in the bill that we passed for Medicare. The Patients' Bill of Rights would extend that protection to other HMOs and other health plans, because patients should never have to wonder if their doctor might lose money by giving additional medical services. The Republican bill is silent on that point. It does not even extend that Medicare protection to other Americans.

An eighth key difference exists in the external appeals process. Virtually everyone who has looked at the problems in managed care recognizes the need to ensure a nonbiased, external review of decisions to deny care, and both bills have external appeals provisions, but they differ on key details. The Republican bill does not make external appeals decisions binding on the plan. If an outside body agrees that the plan should pay for care, it is not binding on the HMO. The bill I support, the Patients' Bill of Rights, has a binding external appeal.

An additional and more troubling difference is the scope and conduct of the external review. The Republican bill does not have any provision for the enrollee to participate or to have experts testify on their behalf. The better bill, the Patients' Bill of Rights, ensures that the enrollee has an opportunity to testify and to have witnesses appear on his behalf if he appeals a denial. And this dovetails with an issue that I raised earlier about gag rules and disclosing safety issues to appropriate authorities.

The Patients' Bill of Rights prevents health plans from taking action against providers who advocate for their patients in the grievance and appeals process. There is no similar protection under the Republican bill. But I guess since they are not even guaranteed an opportunity to testify, I suppose they do not need that protection in the first place.

Another distinction in the appeals process is that the Patients' Bill of Rights guarantees a review on the merits by outside experts as to whether a service or treatment is medically necessary. Under the Republican bill, the outside review is limited to determining whether the plan followed its own definition of medical necessity. That is an enormously important point.

During testimony before the Committee on Commerce 2 years ago, a former medical reviewer for an HMO described how health plans can monkey with the definition of ''medical necessity'' in order to exclude virtually any expensive treatment. She called that medical necessity issue the ''smart bomb'' of care denials. I think it is exceedingly troubling that the Republican bill would prevent the external appeal from being a real review on the merits. In fact, that limited review could actually preempt more protective State laws.

Finally on the issue of external reviews, the Republican bill actually throws up a hurdle to working families. Under the Republican bill, HMOs can require that enrollees pony up as much as $100 just to obtain the limited external appeal. That could pose an unreasonable burden on many Americans most in need of care and should not be in the legislation.

A ninth key difference in the bills is timing. The Patients' Bill of Rights would have to be considered superior to the Republican bill because its protections are effective immediately. By contrast, the Republican bill delays the effective date until at least January 1, the year 2000, and if the bill is not signed into law until early next year, the protections are not effective until the year 2001.

Finally, the bill I support, the Patients' Bill of Rights, establishes State ombudsmen to help consumers better understand and obtain care from their health plans. They can help prospective enrollees make meaningful comparisons of their options and they can help patients navigate through the plan's utilization review system as well as internal and external appeals.

How important is it to have someone knowledgeable on your side? Well, ask this young woman, Jackie Lee. She fell off a 40-foot cliff while hiking in the Shenandoah mountains. She fractured her pelvis, her skull, her arm; she was airlifted to a nearby hospital for care. After getting first class medical care, she also got a first class runaround from her health plan, from her HMO, who refused to pay her hospital bills. They said she had not phoned ahead for prior authorization. I mean, what was she supposed to do after she fell off this 40-foot cliff, wake up from her coma, pull her cellular phone out of her pocket with her nonbroken arm, phone the HMO on a 1–800 number and say hey, guess what, I just fell off a cliff? I mean, come on. At wit's end, she contacted the Maryland State Insurance Commissioner, and that office was able to help Jackie get the coverage to which she was entitled.

Today this young woman is in an ERISA regulated plan. If the same accident would befall her today, the HMO would be beyond the reach of State insurance commissioners, and that is why the Patients' Bill of Rights creates a health insurance ombudsman. The Republican bill, sadly, has no comparable provision.

In summary, Mr. Speaker, the GOP bill is not even half a step forward. In fact, it may be a full step backwards in that it would negate many States' efforts to fix HMO problems.

So I am going to make a few suggestions to make the Republican bill live up to its claims, and here they are. The bill should be amended to include the emergency room protections that we have already enacted for Medicare and Medicaid. The privacy protection should be tightened to prevent inappropriate disclosures of medical records and to leave intact stronger State laws. The provisions on association health plans, which expand the pool of people in ERISA health plans, should be removed. The same is true of health marts which would deny people the protections of some State benefit laws. The bill should prevent health plans from punishing providers who speak up for patients in the appeals process, or who raise safety concerns to appropriate regulatory authorities.

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The bill should give providers input into the plan's drug formulary and ensure that drugs not on the list can be prescribed when medically necessary. The bill should be amended to allow patients access to clinical trials when it offers them the best hope for a cure.

The Republican bill should not allow those with chronic conditions like cancer or arthritis to not have a standing referral to a specialist. It should allow them to have a standing referral to a specialist who can treat that chronic condition.

The point-of-service provision should be strengthened, particularly by deleting the ability of plans to cancel coverage if they speculate that the premium to employees might increase by more than 1 percent.

The bill should have language, like in Medicare, to ensure providers are not given inappropriate financial incentives by HMOs to deny medical care.

The appeals process should be strengthened to allow a new review on the merits, not on whether the plan followed its own definition of medical necessity. Patients and providers should be able to testify without fear of retribution. The outcome of the external review should be binding on the plan, and employees should not have to pay up to $100 for that review.

The bill should include an ombudsman program to help consumers understand their rights. These protections should be made available as soon as possible, and group health plans must be made more accountable for the consequences of their negligence. This is an important point.

Because of a Federal law known as ERISA, patients injured because their HMO delayed or denied treatment have very limited remedies. The Patient Bill of Rights would permit States to set their own rules for such actions.

The Republican bill passed by the House tinkers with but does not really fix this problem. The desperate need for legislation to fix ERISA was outlined in the decision of Federal District Court Judge for the Southern District of Mississippi, Judge Charles Pickering, Senior, in the 1994 case Suggs v. Pan American Life Insurance Company.

Judge Pickering's opinion contained an exhaustive review of the history and interpretation of the ERISA statute: ''Despite this clearly stated objective of ERISA to protect employees from abuse, with so many State laws and/or remedies having been preempted, employees obviously have less protection in the field of health insurance today than they had before ERISA was passed in 1974. It cannot be said that congressional intent has been followed when the results are so clearly to the contrary.''

Judge Pickering went on to observe that ERISA ''has preempted from application to most group health insurance policies a volume of State laws and remedies developed over many years of experience that protected insureds. ERISA has not been interpreted to replace preempted State remedies.''

In a section of the opinion entitled ''Part VII. Frustration,'' Judge Pickering lamented, ''Something is wrong when the law designed to protect employees leaves victims of fraud without a remedy. Either Congress is incapable of writing legislation to accomplish what they plainly say is their intent, or the courts lack the ability to interpret the statute to do what Congress plainly says it intended to do, or both, or a mixture. In any event, the system fails.''

Judge Pickering went on to remark that, ''There is no way of knowing how many Americans today are without health insurance, or have had to take bankruptcy, or how many have simply given up trying to enforce their health insurance policy because they do not want to or cannot afford to come to Federal court to litigate claims that involve so little, and that, by all reason, should be resolved in the lowest State forum available, where costs and expenses and time do not equal that of the Federal judiciary.''

Summing up his consternation over the operation of the ERISA statute, Judge Pickering noted that the history of cases before his court shows that ERISA has not protected employees, but has, instead, denied them a remedy for valid grievances.

''There has not been a single case that has been filed before this court by an employee coming into Federal court saying, 'I want to protect my pension or my benefits under the broad terms of ERISA.' Every single case brought before this court has involved insurance companies using ERISA as a shield to prevent employees from having the legal redress and remedies they would have had under longstanding State laws existing before the adoption of ERISA. It is indeed an anomaly that an act passed for the security of employees should be used almost exclusively to defeat their security and leave them without remedies for fraud and overreaching conduct.''

Judge Pickering's thoroughly researched and well-reasoned opinion demonstrates the compelling need for Congress to fix the problems created by ERISA. I was disappointed that this was not included in the rule, and hope this will be addressed in a positive way in whatever managed care reform bill finally gets passed by the House and Senate and sent to the President.

If these changes are eventually made to the Republican bill, then it will begin to deserve its name: The Patient Protection Act. If not, then the bill is a fig leaf. I look forward to working with my colleagues to help make the final bill one which gives all Americans the protections they need.

Mr. Speaker, a large number of Republicans want to pass meaningful legislation. Ninety Republicans were cosponsors of a much stronger patient protection bill than that that passed the House in July. Most of these Republicans did not have sufficient time to examine the GOP bill before voting on it because it was rushed to the floor to provide political cover.

But Mr. Speaker, those Republicans who want to see signed into law a bill that is really a step forward should demand of our leadership the type of changes I have outlined. If there is a will, there is still plenty of time to get a bipartisan agreement on HMO reform.

However, Mr. Speaker, opponents of strong patient protection legislation may succeed in preventing reform legislation from passing this year. But I guarantee Members, Mr. Speaker, this issue will only get hotter in coming years if Congress does not act to truly curb the abuses of some HMOs.

Mr. Speaker, as Abe Lincoln said, ''You can't fool all of the people all of the time.''

SOCIAL SECURITY, TAXES, AND WHERE WE ARE GOING AS A NATION

The SPEAKER pro tempore (Mr. SNOWBARGER). Under the Speaker's announced policy of January 7, 1997, the gentleman from Wisconsin (Mr. NEUMANN) is recognized for 60 minutes as the designee of the majority leader.

HEALTH CARE IN AMERICA

Mr. NEUMANN. Mr. Speaker, I rise tonight to first address just briefly what my colleagues have been talking to me about, or have been talking about here on the floor in advance of me, and that is health care in America.

We hear so much about HMOs that are not doing their job for their patients, and we think about what kind of solutions we could come up with. There is a very naturally tendency in Washington, D.C. to say Washington needs to solve the problems. One thing Washington might consider doing is empowering the people in this country to have a choice of which HMO they go to and which health care coverage they would like.

Today that is not possible, because if you work at the General Motors plant in Janesville, Wisconsin, General Motors offers you as an employee one of several health care plans. But if you choose not to take the one offered by General Motors in Janesville, Wisconsin, and you instead go and buy some other health care plan, you first lose the benefit through your place of employment, and second, you have to take after tax dollars and go and purchase that other coverage.

One thing I think we should be thinking about as it relates to health care coverage is empowering all Americans to have the option of choosing the health care coverage that they want.

If General Motors could simply say to the employees in Janesville, Wisconsin, where I am from, ''Here is the money that is available for your health care package, now you choose which health care coverage you would like,'' what would happen is the HMOs that are no good, some of those we have been hearing about here from my colleagues as I sat and listened here tonight, those HMOs that are no good and that are treating their patients wrongly and poorly, they would go out of business, because people would choose not to go to those HMOs because of the poor quality of the health care and their coverage.

At the same time, some of the good health care plans, some of the good HMOs, or maybe people do not want HMOs, maybe they want a policy like some of the medical savings accounts, where they take a large deductible and save some of that extra money for themselves, but at any rate, it would be their choice because they would have the choice of where they are going to go for their health care, and we would certainly expect the good health care plans to thrive and provide good coverage. Just like when I was in the homebuilding business, service to our customers was our top priority, because I knew my customers were going to talk to other people about the homes we built for them.

Similarly, if people have choices in health care programs, if people can go anywhere they want for those health care programs, service to the customer becomes the top priority, because if they do not do a decent job people are going elsewhere for their health care coverage.

When we think about that as a solution, as opposed to here in Washington somehow knowing what is best for everybody all across America, I sure like the idea of empowering the people as opposed to making us more in control of more parts of the people's lives.

That is not really what I rose to talk about tonight, but I listened to the gentleman before me and I thought we should throw out another suggestion as to how to move America forward as it relates to health care.

I want to say tonight that it is a very solemn mood here in Washington, D.C., to the folks that are watching from all around the country, Mr. Speaker. They should know that the mood here in Washington, D.C. is a very solemn situation. We here in the House take our responsibility that we have been given very, very, very seriously. It is not about Republicans or Democrats at all out here. We understand that we are at an important time in America's history.

What happens over the next few months as it relates to the matter that is currently before us is certainly going to take up the news, but there is something else that is real important here. As the Starr report is being discussed, and as the potential impeachment proceedings go forward and all that stuff dominates the news out there, the normal business of Congress is still going on behind the scenes.

There are some very, very significant things happening right here in Washington right now behind the scenes and below the level of the news because of the Starr report and what is happening there that are going to affect things that are as important to Americans as Social Security and taxes, and whether or not we stay in balance and pay down our debt. Things that are extremely important to the future of this country are still going on over the next 4 or 5 months in addition to the other very serious responsibility that we, as all Americans, have.

For that reason I rise tonight to talk about, in particular, Social Security and taxes and where we are going as a Nation, a little bit about how far we have come, but where we are at right now.

If we look at numbers today, for the first 11 months of our fiscal year we are running a surplus that is very, very substantial for the first time since 1969. It is not a little, tiny surplus, it is almost $100 billion a year. We have been projecting between $80 and $106 in my office for quite some time. It appears now that the numbers will come in someplace in between there.

Let me put that in perspective so it makes more sense, because out here in Washington we talk about these billions all the time. It does not always make sense to all my colleagues and all the people all across America.

A $100 billion surplus means that the United States government has collected $400 for every man, woman, and child in the United States of America more than what it needed in taxes. Let me say that again. A $100 billion surplus is approximately $400 for every man, woman, and child in the United States of America. We are talking about a huge amount of money.

I want to just talk about how that surplus relates back to debt, to deficit, to Social Security, and to tax cuts as we move forward, because there is a very significant debate going on right now as to how that surplus should be used. It relates specifically to the Social Security issue.

First, let me start by pointing out that we still have a very serious problem facing this country. This debt chart, and I notice tonight it is actually worn out, because I think I start most every presentation by showing this debt chart. It shows the growing debt facing America.

If we start down here, we can see from 1960 to 1980 there was very little growth in the debt, but from 1980 forward, this thing has just grown right off the wall. When I am out in public and I point out 1980 as where it really started growing, or 1978, 1979, I can see all the Democrats in the audience nodding their heads, going, ''That was Ronald Reagan,'' and I can see all the Republicans nodding their heads and saying, ''That was that Democrat Congress.'' The point is, whether we were Democrat or Republican, it did change in 1980 or thereabouts. We are about up